ژورنال کلاب

استاد : خانم دکتر مطلبی

دانشجو : ولی اله معروف خانی

عنوان

The effect of education on knowledge and management of elder abuse: a randomized controlled trial

نقاط قوت :

- عنوان مقاله منعکس کنندۀ محتوا و متغیرهای آن است
- در عنوان از اختصارات مبهم و کلمات نامأنوس استفاده نشده است
- عنوان مقاله جامع و مانع و گویاست و هیچ ابهامی ندارد
- از به کاربردن کلمات اضافه در عنوان پرهیز شده است
- دارای جذابیت برای جذب مخاطب است
- عنوان به صورت فشرده و در ذهن قابلیت ماندگاری دارد

نقاط ضعف :

- آوردن نوع مطالعه وآوردن کلمه ی The در ابتدای عنوان

نویسندگان

Barbora Richardson[2], Ginnette Kitchen[1], Gill Livingston[2]

Camden and Islington NHS Mental Health Trust, Waterlow Unit and
[1]Department of Psychiatry & Behavioural Sciences, Whittington Hospital, London, UK
[2]Royal Free & University College Medical School, University College London, Department of Psychiatry and Behavioural Sciences, Gower Street Campus, 48 Riding House Street, London WIN 8AA, UK

Address correspondence to: G. Livingston. Fax: (+44) 207 530 2304. Email: g.livingston@ucl.ac.uk

نویسندگان

نقاط قوت :

- نام نویسندگان بعد از عنوان موضوع ذکر شده است
- مشخصات نویسندگان بعد از نام آنها آورده شده است
- مرتبه های علمی و نویسنده مسئول، مشخص شده است
- آدرس و مشخصات نویسنده مسئول برای پاسخگویی ذکر شده است

نقاط ضعف : (-)

چکیده

Abstract

Background: abuse of older adults may occur to a disproportionate extent in institutions. Lack of familiarity with protocols when managing abuse once it occurs is one of the reasons why it persists. Educational interventions are one of the ways to improve knowledge and management in this area.

Objective: to compare the effectiveness of attending an educational course (Group 1) to printed educational material (Group 2) in improving management of abuse of older people. To determine if positive attitude and low burnout scores are related to improvement.

Design: randomized controlled trial.

Setting: North London, UK.

Subjects: nurses, care assistants and social workers working with older people.

Methods: staff answered questionnaires pre- and post-intervention.

Results: the study was completed by 64 (81%) of staff. Baseline scores on knowledge and management abusive scenarios were low. Those randomized to Group 1 improved after intervention and Group 2 deteriorated (Group 1 = 3.7 [standard deviation = 8.1], ANOVA F = 23.0; $P = 0.0001$ and Group 2 = −2.9 [standard deviation = 10.0]). There was a ceiling effect with those who knew more learning less. The significant independent variables in regression analysis to predict learning were being randomized to Group 1 ($P = 0.003$; odds ratio = 6.8; 95% confidence interval = 1.9–24.5) and low baseline knowledge and management score, ($P = 0.015$, odds ratio = 4.8, confidence interval = 1.4–16.9). Most staff had a positive attitude towards people with dementia; positive attitude score correlated with baseline knowledge, but did not predict learning.

Conclusion: identifying, documenting and reporting abuse of older people is not carried out consistently. Whilst an educational course goes some way in improving this, it needs to be targeted to take into account the baseline knowledge.

چکیده

مقدمه : ممکن است سوءرفتار وسالمندآزاری بیش از حد در سازمانها روی دهد یکی از دلایل تاکید بر این موضوع عدم آشنایی با پروتکل ها به هنگام مدیریت سوءاستفاده میباشد.مداخلات آموزشی یکی از روشهای بهبود آگاهی ومدیریت در این زمینه میباشد.

هدف : برای مقایسه اثر بخشی شرکت در دوره ی آموزشی (گروه۱) تا مطالب آموزشی چاپ شده (گروه۲) در بهبود مدیریت سالمند آزاری. جهت تعیین اینکه آیا نگرش مثبت وامتیاز خستگی مفرط جهت بهبود وضعیت به هم مرتبط هستند یا نه؟

طرح : آزمایش کنترل شده تصادفی

موقعیت : شمال لندن، بریتانیا

افراد مورد آزمایش : پرستاران، دستیاران مراقبتی و کارگران اجتماعی که با افراد مسن کار می کنند.

روش ها : پرسنل قبل و پس از مداخله به پرسشنامه ها پاسخ دادند.

چکیده

- **نتایج :** تحقیق حاضر توسط ۶۴ نفر از پرسنل (۸۱%) تکمیل گردید. نمرات پایه آگاهی و مدیریت سناریوهای سوء استفاده پایین بود. آن دسته از افرادی که به طور تصادفی در گروه ۱ بودند بعد از مداخله بهبود یافتند و وضعیت افراد در گروه ۲ بدتر شد(گروه ۱= ۷/۳ [انحراف معیار=8.1]، ANOVA F=23.0, P=0.0001 و گروه ۲= ۹/۲ [انحراف معیار =10.0]. در مورد آن دسته از افرادی که درباره یادگیری بیشتر کمتر می دانستند اثر تارک وجود داشت. متغیرهای مستقل معنادار در تحلیل رگرسیون برای پیش بینی یادگیری به طور تصادفی در گروه ۱ (p= 0.003 =)، نسبت احتمال = 6.8، فاصله اطمینان ۹۵% =-1.9 24.5) و نمره پایین مدیریت و آگاهی پایه (p= 0.015 =)، نسبت احتمال=4.8، فاصله اطمینان=16.9-1.4) قرار گرفتند. اکثر پرسنل نگرش مثبتی نسبت به افراد دارای دمانس داشتند، نمره نگرش مثبت با آگاهی پایه در ارتباط بود ولی یادگیری را پیش بینی نکرد.
- **نتیجه گیری :** شناسایی، سندسازی و گزارش سوء استفاده از افراد سالخورده به طور منسجم انجام نگرفت. درحالی که دوره آموزشی روشی برای بهبود این امر می باشد باید دانش و آگاهی پایه را نیزدر نظر گرفت.

چکیده

نقاط قوت :

- چکیده تصویر روشنی از محتوای مقاله را ترسیم میکند
- هدف و اهمیت کلی و قلمرو تحقیق مشخص شده است
- روش تحقیق و گردآوری داده ها و تجزیه و تحلیل نتایج بیان شده است
- چکیده به صورت کوتاه و خلاصه و جامع به ارائه مطالب پرداخته است
- جامعه و نمونه و روش نمونه گیری بیان شده است
- چکیده خواننده را برای مطالعه متن مقاله ترغیب میکند
- فرمول و علائم ویژه، بیان نشده است
- پژوهشگر به قضاوت شخصی در مورد نتایج تحقیق نپرداخته است

نقاط ضعف :

- نوع پرسشنامه ها اشاره نشده است.

کلیدواژه

Keywords: *abuse of elderly, education, randomized controlled trial*

۱ . کلید واژه ها ارتباط موضوعی لازم با محتوای مقاله را دارند
۲ . تعداد استاندارد کلید واژه ها رعایت شده است
۳ . کلید واژگان بر اساس بیشترین و نزدیک ترین رابطه معنایی با محتوای مقاله انتخاب شده اند
۴ . از تکرار کلید واژها، پرهیز شده است

بیان مساله

Introduction

Background and scientific rationale

In 1975, Baker coined the phrase 'granny battering' to describe a newly identified problem; physical abuse of older people [1]. At first, as with any new concept, the idea had variable acceptance [2]. As recently as 1991, the then Minister for Health stated that abuse of older people was not a major issue. There is now, however, general and governmental acceptance that elder abuse is a problem, which has resulted in the Department of Health policy entitled "No Secrets" [3].

Research regarding elder abuse has focused primarily on characteristics of the abused person and suggests that people with dementia may be particularly vulnerable [4]. More contemporary emphasis has moved to the circumstances and abuser.

Abuse may occur to a disproportionate extent in institutional settings. One large survey of staff working

بیان مساله

in nursing homes found that 36% had observed physical abuse and 81% witnessed psychological abuse [5]. In the UK, over 25% of telephone calls to the Action on Elder Abuse helpline, raised concerns about institutional settings [6].

Colin-Shaw has suggested that mistreatment of older people by staff can be conceptualized as sadistic or reactionary [7]. The latter occurs when a person has been asked to do too much with insufficient personal or training resources. Thus a negative attitude towards patients and their behaviour has been explained by emotional exhaustion [8], and staff who admitted to physical abuse were frequently thinking of quitting, scored high on burnout and experienced high conflict with patients [9]. Garner and Evans summarise the literature and conclude that carers need to learn skills so that they can make sense of complicated communications from their patients without becoming overwhelmed by punitive feelings [10].

It is unclear how to change the behaviour and attitude of staff. A Cochrane review of the effectiveness of education on changing the behaviour of health care professionals and patient outcomes compared printed material with either no intervention, or educational packages, such as attending seminars [11]. They found 'at best a modest effect' of printed material on practice of professionals. In contrast, one study found that attendance at an abuse detection programme was effective, in that there was a self-reported decrease in abuse from 11% to 5% [12].

Protocol

The Local Ethics Committee gave approval to the protocol. Potential participants were approached by either BR or GK, given an information sheet and a consent form. The recruitment and follow-up period was October 1999 until August 2000. The mean time to follow-up was 29 days following recruitment.

Assignment

All eligible participants were randomized using computer-generated numbers into either Group 1 or 2 (see Figure 1). The randomization was concealed until the intervention was allocated.

Interventions

Group 1 attended an educational course commissioned by the employing NHS trust and social services. Those in Group 2 were given reading material with the same content as the course. The programmes targeted identification and management of all types of abuse i.e. neglect, verbal, physical and financial abuse. They were based on the policy, practice guidance and procedures on responding to abuse and inadequate care of vulnerable adults which was operational in both health and social services.

بیان مساله

Objectives and hypotheses

There has been little work evaluating the effect of educating staff to increase their skills to deal with abuse. The primary objective of this study was to measure whether attendance at an educational course is superior to printed educational material alone in improving knowledge and management when dealing with a range of abuse of older people. The secondary objective was to examine whether improvement in such knowledge and management is associated with improved attitude to older patients with dementia and decreased staff burnout.

پیشینه و توجیه علمی :

در سال ۱۹۷۵ بیکر عبارت "ضرب و جرح مادربزرگ" را برای توصیف مشکل به تازگی شناسایی شده، تحت عنوان سوء استفاده فیزیکی از افراد سالخورده، ابداع کرد [۱]. در ابتدا همانند هر مفهوم جدید این ایده

پذیرش متغیر داشت [۲]. در اواخر ۱۹۹۱ وزیر بهداشت وقت اذعان نمود که سوء استفاده از افراد سالخورده موضوع مهمی نیست تحقیق مربوط به سوء استفاده از افراد مسن اساسا بر ویژگی های فرد مورد سوء استفاده قرار گرفته تاکید داشته و نشان می دهد که ممکن است افراد دارای دمانس به طور خاص در معرض آسیب باشند[۴]. امروزه تاکید بیشتر بر شرایط و سوء استفاده کننده شده است.

کولین شاو پیشنهاد نموده است که بدرفتاری پرسنل با افراد مسن می تواند به عنوان رفتار سادیست یا ارتجاعی (واکنشی)مفهوم سازی شود .گارنر و ایوانس ادبیات و تحقیقات قبلی را جمع بندی کردند و نتیجه گرفتند که مراقبت کنندگان باید مهارت هایی را یاد بگیرند به طوری که بتوانند از روابط پیچیده بیماران خود سردر بیاورند بدون اینکه غرق در احساسات تنبیهی شوند.

بیان مساله

نقاط قوت :

- اهمیت و ضرورت انجام تحقیق بیان شده است
- اهداف آن از نظر کاربردی و بنیادی بیان شده است
- سوابق پژوهشی استفاده شده با موضوع در ارتباط مستقیم است
- اهمیت مسئله در حدی هست که نیاز به ارائه مقاله مستقل باشد
- در بیان مسئله روانی و صراحت لازم لحاظ شده است
- حدود و ابعاد و جوانب مسئله به روشنی بیان شده است

نقاط ضعف : (-)

بررسی متون

نقاط قوت :

- پیوند موضوع مقاله با سابقهٔ پژوهشی آن به روشنی ترسیم شده است
- پیشینه تحقیق در تدوین گزاره های تحقیق موثر بوده است
- پیشینه تحقیق در بیان مسئله و محدود سازی آن موثر بوده است
- رو یکرد نویسنده در تدوین پیشینهٔ پژوهش تحلیلی است
- خواننده می تواند با منابع مرتبط با موضوع از طریق مقاله آشنا شود.
- محدوده زمانی مورد بررسی مشخص شده است

نقاط ضعف : (-)

هدف

Objectives and hypotheses

There has been little work evaluating the effect of educating staff to increase their skills to deal with abuse. The primary objective of this study was to measure whether attendance at an educational course is superior to printed educational material alone in improving knowledge and management when dealing with a range of abuse of older people. The secondary objective was to examine whether improvement in such knowledge and management is associated with improved attitude to older patients with dementia and decreased staff burnout.

هدف

درخصوص ارزیابی تاثیر آموزش پرسنل بر افزایش مهارت های آنها برای مقابله با سوء استفاده تحقیقات کمی صورت گرفته است. هدف اصلی این تحقیق ارزیابی این است که آیا در زمان رویارویی با دامنه ای از سوء استفاده های مختلف از افراد مسن شرکت در دوره آموزشی بهتر از مطالب آموزشی چاپ شده در بهبود دانش و مدیریت است یا نه. دومین هدف بررسی این است که بهبود چنین دانش و مدیریتی به بهبود نگرش پرسنل نسبت به بیماران سالخورده دارای دمانس و کاهش خستگی آنها مربوط می شود یا خیر.

هدف

نقاط قوت :

- هدف مقاله به روشنی توصیف و تبیین شده است
- هدف مقاله متناسب با بیان مسئله تدوین شده است
- خواننده بدون دشواری می تواند هدف مقاله را در متن اصلی بیابد

نقاط ضعف : (-)

Methods

Eligibility criteria

Eligible participants were all those employed by the local community health trust or social services who worked with older people, and had not yet attended a course on managing abuse of older people. This encompassed nursing staff, care assistants, care managers and social workers. This trust had a policy on management of elder abuse in place prior to the study being carried which was consistent with "No secrets" [3].

Masking

The participants unavoidably knew to which arm of the trial they had been allocated. The tutor of those in Group 1 was blind to who was participating in the study. The raters were blind to the allocation, as there was no indication on the completed assessment either concerning the identity of the participants or which group they had been randomized to or whether the instrument being scored was pre- or post-intervention. The group allocations were disclosed after scoring was completed.

جامعه وحجم نمونه

- **افراد مورد آزمایش** : پرستاران، دستیاران مراقبتی و کارگران اجتماعی که با افراد مسن کار می کنند.
- **حجم نمونه و تحلیل موقتی**

ما حجم نمونه را با استفاده از انحراف معیار معمولی و تغییر میانگین نمرات برای پانزده نفر اول تکمیل کننده فرم ها در گروه های ۱ و ۲ محاسبه نمودیم و برای آزمون دو طرفه توانایی ۹۰% و 5.0 و انحراف معیار 4.0 قرار دادیم. تغییر میانگین 0.01معناداری بود. ما دریافتیم که در هر شاخه تحقیق به ۳۰ شرکت کننده نیاز خواهیم داشت.

نقاط قوت :

- جامعهٔ آماری مورد مطالعه و ویژگی های آن به دقت معرفی شده است
- شیوهٔ نمونه گیری و دلایل انتخاب این شیوه به روشنی تشریح شده است
- چگونگی تعمیم بخشی نتایج حاصل از نمونه به جامعه تبیین شده است

نقاط ضعف : (-)

Outcome measures

The participants were asked to complete a set of questionnaires before and after the research intervention.

Knowledge and management questionnaire (KAMA)—vignette questionnaire

Investigators have used vignettes since the 1950s to encourage discussion of topics that respondents might find particularly difficult [13]. Vignettes have also been used in the field of elder abuse to find out about GPs' experiences of a range of abusive situations [14]. This method allows the candidate to be presented with a wide range of problems quickly with little practical inconvenience. Examiners use realistic or actual clinical scenarios, which the specialist institutions find helpful in distinguishing between candidate competency. Hayes *et al.* [15] conclude that vignette-based instruments are useful in identifying the areas of knowledge that improve following an educational intervention. Almquist *et al.* [16] examined the predictive value of (i) written-knowledge

tests (ii) a multiple-station examination and (iii) an actual medical performance compared to a videoed consultation. The score on the written knowledge test was comparable to the score obtained when real consultations were assessed (Pearson's correlation coefficient ranging from 0.43 to 0.56).

As KAMA was to be measured twice, we developed a parallel form questionnaire (A and B) consisting of seven vignettes with open questions about what the staff member should do in the scenario described. At baseline, version A was given to every other participant and version B to the rest, at follow-up those who were given A at baseline received B and vice versa.

Participants were asked to give as full an answer as possible. Standard comprehensive answers were developed based on the written teaching material. All answers had a core component, which encompassed ensuring safety of the abused person, recording and reporting the abuse. An example of a vignette and the model answer is given in Figure 2. The total possible score from the form of questionnaire B was higher than A, therefore the modified total score is expressed in percentages.

The Maslach Burnout Inventory (MBI)

The MBI [17] consists of three components; emotional exhaustion, personal accomplishment and depersonalization; frequency and intensity of thoughts and emotions. Scores are grouped into three ranges, high, medium and low burnout. Missing scores are dealt with by using the mean.

The Maslach Burnout Inventory (MBI)

The MBI [17] consists of three components; emotional exhaustion, personal accomplishment and depersonalization; frequency and intensity of thoughts and emotions. Scores are grouped into three ranges, high, medium and low burnout. Missing scores are dealt with by using the mean.

Attitude of Health Care Personnel towards Demented Patients (AHCPDP)

The AHCPDP [18] scale employs a five point Likert scale. Total score represents an overall positive or negative attitude. The author gives norms for multidisciplinary staff. These were positive for 85% of those working in old age psychiatry and 73% of qualified nurses. Possible scores range between 1 and 30 for positive attitudes and –1 to –30 for negative attitudes. Missing items are dealt with by using the mode.

Analytical methods

Data were entered into SPSS-PC.

Methods used to enhance the quality of measurements

Validity and reliability analyses of the KAMA internal consistency was measured by comparing the relationship between the total score and individual item scores of the vignettes and Cronbach's alpha was computed. Alternate forms reliability coefficient was calculated for versions A and B. Inter-rater reliability was measured by two raters scoring (GK and BR) a random sample of the questionnaires independently and an agreement

coefficient was calculated. Construct validity was computed using Spearman's correlation coefficient for the total vignette score and grades of professional standing and years of experience.

Difference between randomized groups

We examined differences between completers in Groups 1 and 2 in demographics and scores on baseline questionnaires. We analyzed nominal data using chi-squared statistic; relative risks (RR) and 95% confidence intervals (CI) were calculated. Mean scores and standard deviation (SD) were calculated reported in knowledge and management, attitude and burnout scales. Changes in the mean scores between randomized groups were analyzed using independent *t*-test and the ANOVA when there were baseline differences between groups to ensure that baseline difference differences were accounted for in the analysis [19].

Analysis of learning

We created a dichotomous variable for learning (we defined learning by the KAMA score increasing). We examined how learning was related to demographic variables, randomization and change in attitude and burnout scales. We used Spearman's correlation to examine if baseline score on KAMA questionnaire or length of experience was correlated with improvement in score.

Logistic regression was used to find significant independent predictors of learning; odds ratio (OR) and 95% CI were calculated. The independent variable randomization group, gender, years of experience, attitude, initial KAMA score was dichotomized at the median, grade of staff, whether employed by health or social services and whether the initial vignettes were A or B were entered as possible predictors of learning.

Sample size and interim analysis

We calculated sample size using the common standard deviation and the mean change in scores for the first fifteen completers in Group 1 and 2, set at 90% power and 0.01 significance for a two sided test. Mean change was 4.0 and standard deviation of 5.0. We found that 30 participants would be needed in each arm of the study.

ابزارها

- ✓پرسشنامه ی دانش ومدیریت درسوء استفاده (KAMA)
- ✓پرسشنامه ی فرسودگی روانی ماسلیچ(MBI)
- ✓پرسشنامه نگرش پرسنل بهداشتی به بیماران دمانسی(AHCPDP)

ابزار ها و روش تحقیق

نقاط قوت :

- روش تحقیق به روشنی تبیین و توصیف شده است
- تناسب کارآیی روش مورد استفاده با اهداف پژوهش ذکر شده است
- ابزار گردآوری داده ها و روش تحلیل آنها به روشنی معرفی شده اند
- متغیر های مورد استفاده در تحقیق تعریف شده اند

نقاط ضعف :

- دلایل انتخاب روش مورد استفاده ذکر نشده است
- دلایل عدم انتخاب سایر روشهای مشابه ذکر نشده است
- مزایا و معایب همه ی ابزارها بکارگرفته شده به دقت تشریح نشده است
- نمونه هایی از کاربرد این ابزار در سایر پژوهش ها ذکر نشده است

Results

Reliability and validity of knowledge and management questionnaire

Reliability

Internal consistency. The item-total correlation of individual questions and total score ranged from 0.46 to 0.89 for version A of the questionnaire and 0.46 and 0.79 for version B. Cronbach's alpha for form A was 0.78 and for form B 0.76.

Inter-rater reliability employing two-tailed Pearson's correlation coefficient was 0.978 ($P=0.01$).

Test retest reliability was calculated by two tailed Pearson's correlation coefficient as 0.685 ($P=0.01$).

Validity

Concurrent validity. Baseline KM scores correlated with years of experience. Version A: Spearman's correlation 0.47, $P=0.001$; version B: 0.42, $P=0.05$. The baseline mean score on KM was significantly associated with whether the respondents were qualified or were care assistants (version A Mann–Whitney $Z=4.5$, $P=0.000$; version B Mann–Whitney $Z=2.6$, $P=0.009$).

Parallel form validity. There was no significant difference between the pre-intervention scores for version A of the questionnaire at 26.8 (SD 14.3) and version B at 24.0 (SD 8.8).

Flow and follow-up of participants

Of the 87 people approached by the researchers, one refused to participate. The baseline assessment was completed by 79 participants, of whom 7 refused the post-intervention assessment. Follow-up data was obtained on 64 (81%) of those who consented to take part. Table 1 shows the characteristics of participants compared to non-participants and non-completers. There were no significant differences.

From now on we analyse data from the 64 people who completed the study. Tables 2 and 3 show characteristics of those randomized to Groups 1 and 2. There were no significant differences in those randomized to either intervention group in terms of gender, years of experience, professional status, whether employed by health or social services, attitude to people with dementia and burnout scores. There was a significant difference at baseline in KAMA scores ($P<0.05$) with those randomized to Group 2 scoring higher.

There was a significant difference between intervention groups in final KAMA score with those randomized to Group 1 improving after intervention and Group 2 deteriorating (Group 1 = 3.7 [SD = 8.1], ANOVA $F=23.0$; $P=0.0000$ and Group 2 = –2.9 [SD = 10.0]). There was no difference in change in scores between the parallel forms of the questionnaire (A and B) in each randomization group.

Those who knew less learnt more; baseline scores correlated negatively with improvement on KAMA questionnaire for both intervention groups (Group 1 Spearman's correlation = –0.394, $P=0.028$ and Group 2 Spearman's correlation = –0.551, $P=0.001$). Improvement in scores on KAMA questionnaire was not correlated with either experience or associated with place of employment (health or social services).

Learning was highly associated with being randomized to Group 1; 26/31 (83.9%) compared to 5/33 (15.2%) in Group 2 (chi square=11.7; P=0.001; OR=7.1 95% CI=2.2–23.0). The only significant variables in a logistic regression analysis to predict learning were being randomized to Group 1 (P=0.003; OR=6.8; 95% CI 1.9–24.5) and low baseline KM score, (P=0.015, OR=4.8, CI=1.4–16.9).

Attitude to people with dementia

At baseline 96.9% of staff had a positive attitude as measured with the AHCPDP instrument [18] and attitudes was significantly correlated with KAMA (Spearman's correlation=3.71; $P<0.0001$). Neither intervention produced significant change in attitude. Learning on the KAMA was not associated with attitude change.

When attitude was compared to mean years of experience, there was no significant difference between the groups before or after the educational intervention.

Trained staff had a significantly more positive attitude than untrained staff (pre-intervention mean attitude score=13.5; SD 5.4 and 5.6; SD 4.2, respectively; $P<0.0001$; mean difference 7.9; CI=5.1–10.7) and post-intervention (mean score=14.3; SD 5.5 and 6.2; SD 5.3, respectively; $P<0.0001$; mean difference 8.2; CI=5.0–11.2).

Table I. Characteristics of participants and non-participants

	Participants (n=64)	Non participants (n=22)
Female gender	51 (79.7%)	16 (72.7%)
Professional group		
Qualified nurses	23 (35.9%)	7 (31.8%)
Care assistants	34 (53.1%)	12 (54.5%)
Other staff	7 (10.9%)	3 (13.6%)
Mean years of experience	12.5 (SD=9.3)	8.8 (SD=5.7)
Randomization to course attendance	31 (48.4%)	13 (59.1%)

Burnout

Scores on the subscales of the MBI showed that burnout was generally low pre-intervention and personal accomplishment was moderate. There were no significant differences between the randomized groups before or after intervention (see Table 3). Learning was not associated with change in burnout score.

Table 2. Characteristics according to randomization group. Group 1 attended an educational course, Group 2 were given educational material

	Group 1 ($n=31$)	Group 2 ($n=33$)
Female gender	24 (77.4%)	27 (81.8%)
Professional group		
Qualified nurses	9 (29.0%)	14 (42.4%)
Care assistants	19 (61.3%)	15 (45.5%)
Other staff	3 (9.6%)	4 (12.1%)
Health/social services employer	10/21	10/23
Mean years of experience	11.1 (SD = 10.0)	13.7 (SD = 8.5)
Mean attitude	9.5 (SD = 6.5)	8.8 (SD = 5.9)
Mean KAMA score	22.3 (range = 12.1–51.8; SD = 9.6)	28.5 (range = 8.9–58.9; SD = 13.3)

Table 3. Comparison of burnout scores between the randomized groups at baseline

MBI subscale	Group 1 pre-intervention	Group 2 pre-intervention ($n=24$)	Group 1 post-intervention	Group 2 post-intervention
Emotional exhaustion				
Frequency	16.9 SD = 9.4 (low ⩽17) $N=30$	17.6 SD = 11.9 (moderate 18–29) $N=31$	15.2 SD = 7.8 $N=29$	16.7 SD = 11.7 $N=30$
Intensity	21.9 SD = 10.5 (low ⩽25) $N=26$	22.3 SD = 12.2 (low ⩽25) $N=24$	18.2 SD = 9.1 $N=27$	19.4 SD = 12.7 $N=29$
Depersonalization				
Frequency	2.1 SD = 3.5 (low ⩽5) $N=29$	3.0 SD = 3.4 (low ⩽5) $N=32$	3.0 SD = 4.1 $N=29$	3.2 SD = 4.1 $N=29$
Intensity	2.9 SD = 4.7 (low ⩽6) $N=29$	5.3 SD = 7.5 (low ⩽6) $N=28$	3.8 SD = 4.7 $N=30$	5.5 SD = 8.3 $N=30$
Personal accomplishment				
Frequency	36.7 SD = 7.3 (moderate 34–39) $N=30$	38.4 SD = 6.7 (moderate 34–39) $N=32$	36.9 SD = 8.4 $N=30$	36.4 SD = 10.1 $N=29$
Intensity	36.8 SD = 12.5 (moderate 37–43) $N=26$	39.2 SD = 12.2 (moderate 37–43) $N=23$	35.3 SD = 8.1 $N=28$	36.1 SD = 8.9 $N=25$

یافته ها و نتایج

نقاط قوت :

- نتایج و یافته های پژوهش به روشنی توصیف و تبیین شده اند
- نمودارها و جدول های ارائه شده در بخش نتایج گویا و روشن هستند
- یافته های مقاله هدف های اولیهٔ مقاله را تأمین می کند.
- پس از توصیف نتایج سهم کافی به تحلیل آنها اختصاص داده شده است.

نقاط ضعف: (-)

Discussion

The main findings of this study were that there was a lack of knowledge of good management in dealing with elder abuse and that educational seminars were superior to printed material in increasing knowledge and good management in this field.

Knowledge and management in the management of abuse

It is vital that staff are able to identify abusive situations and are confident in their management. In the past, perpetrators of abuse have survived in institutions because staff are frequently unsure of what to do, whom to tell and how to proceed if managers do not take action [20]. Our study found that at baseline staff often do not recognize, record and report abuse.

As in other studies the educational literature did not increase knowledge despite staff knowing that they would be re-tested [11].

We had not expected to find that those who knew more at the beginning learnt less as their greater baseline scores indicate either greater interest, time spent learning or ability to learn. This ceiling effect could be explained by a limited scope for learning. Tailoring courses according to the initial knowledge of participants is essential.

Attitude to people with dementia

This study found that while a positive attitude to people with dementia was highly correlated with baseline knowledge, learning was not associated with change in attitude. As most staff had an initial positive attitude, we would not necessarily expect an improvement as they learnt. Qualified staff had a more positive attitude than unqualified, but there was no difference in attitude according to length of experience. This accords with most but not all previous studies [21, 22].

Burnout

We found that burnout scores were relatively low although previous studies had reported higher levels in staff employed in similar jobs, comparable to other health care workers [5, 23]. We are unclear as to why the staff in our study had relatively satisfactory scores and wonder if this is a 'survivor' effect. The mean years of experience of staff was more than 12 years and it may be that those staff who are most stressed and dissatisfied leave quickly and this would lead to low prevalence of burnout.

بحث ومحدودیت و پیشنهاد

نقاط ضعف :

تشابهات و تفاوت با مطالعات دیگر مطرح نشده است

محدویت ها ذکر نشده است

راهکارهای برای این محدودیت ذکر نشده است

توصیه برای مطالعه های بعدی مطرح نشده است

نقاط قوت: (-)

ACKNOWLEDGMENTS

تشکروقدردانی مطرح نشده است.

References

1. Baker A. Granny battering. Modern Geriatr 1975; 5: 20–4.

2. Bennett G, Kingston P. Elder Abuse: Concepts, Theories and Interventions. London: Chapman and Hall, 1993.

3. Department of Health. No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse. London: Department of Health, 2001.

4. Compton SA, Flanagan P. Elder abuse in people with dementia in Northern Ireland: Prevalence and predictors in cases referred to a psychiatry of old age services. Int J Geriatr Psychiatry 1997; 12: 632–5.

5. Pillemer K, Moore DW. Abuse of patients in nursing homes: Finding from a survey of staff. Gerontologist 1989; 29: 314–20.

6. Jenkins G, Asif Z, Bennett G. Listening is not enough: An analysis of calls to Elder Abuse Response—Action on Elder Abuse National Helpline. Brighton: Pavillion Publishing, 2000.

7. Colin-Shaw M. Nursing home resident abuse by staff: exploring the dynamics. J Elder Abuse 2001; 9: 1–21.

8. Novak M, Chappell NL. Nursing assistant burnout and the cognitively impaired elderly. Int J Aging Hum Dev 1994; 39: 105–20.

9. Smith S, Jepson V, Perloff E. Attitudes of nursing care providers toward elderly patients. Nursing Health Care 1982; 93–8.

10. Garner J, Evans S. Institutional Abuse of Older Adults (Council Report CR84) Psychodynamic Perspective of Elder Abuse. London: Royal College of Physicians.

11. Freemantle N, Harvey EL, Wolf F, Grimshaw JM, Grilli R, Bero LA. Printed educational materials to improve the behaviour of health care professionals and patient outcomes. Cohrane Library 1997.

12. Pillemer K, Hudson B. A model of abuse prevention. Gerontologist 1993; 38: 128–31.

13. Herskovits MJ. The hypothetical situation: a technique of field research. J Anthropology 1950; 6: 32–40.

14. McCreadie C, Bennett G, Tinker A. General practitioners' knowledge and experience of the abuse of older people in the community: report of an exploratory research study in the inner-London borough of Tower Hammlets. Br J Gen Pract 1998; 48: 1687–8.

15. Hayes RP, Stoudemire A, Kinlaw K, Dell ML, Loomis A. Qualitative outcome assessment of a medical ethics programme for clinical clerkship: a pilot study. Gen Hosp Psychiatry 1999; 21: 284–95.

16. Ram P, van der Vleuten C, Rethans J, Schoten B, Hobma S, Grol R. Assessment in general practice: the predictive value of written-knowledege tests and multiple-station examination for actual medical performance in daily practice. Med Educ 1999; 33: 197–203.

17. Maslach C, Jackson SE. Consulting Psychologists Press. Palo Alto, USA: The Maslach Burnout Inventory, 1981.

18. Astrom S, Adolfsson R, Sandman PO, Wedman I, Winbald B. Attitudes of health care personnel towards demented patients. Compr Gerontol 1987; 1: 94–9.

19. Vickers AJ, Altman DG. Analysing controlled trials with baseline and follow up measurements. Br Med J 2001; 323: 1123–4.

20. Andrews S. Beech House Inquiry. London: Camden and Islington Community Services NHS Trust, 1998.

21. Almquist E, Stein S, Weiner A, Linn M. Evaluation of continuing education for long-term care personnel: Impact upon attitudes and knowledge. J Am Geriatr Soc 1981; 29: 117–22.

22. Gillis M. Attitudes of nursing personnel toward the aged. Nursing Res 1973; 22: 517–20.

23. Goodridge D, Johnston P, Thomson M. Impact of a nursing assistant training program and job performance, attitudes, and relationship with residents. Educ Gerontol 1997; 23: 37–51.

رفرنس

نقاط مثبت :

به تعداد مجاز استفاده شده است.

تا حدودی از منابع جدید استفاده شده است.

نقاط منفی : (-)